FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. **IDPH Facility ID Number:** 0046847

Facility Name: Watseka Rehabilitation & Health Care Center

Address: 715 East Raymond Road (Number) Watseka (City) 60970 (Zip Code)

County: Iroquois

Telephone Number: 815-432-5476 **Fax #** 815-432-5669

IDPA ID Number: 743055934010

Date of Initial License for Current Owners: 1/1/2005

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact
Name: Christine A. Hanover **Telephone Number:** (312) 634-4581
Please send copies of desk review and audit adjustments to address on this page

II. **CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Watseka Rehabilitation & Health Care Center # 0046847 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	123	Skilled (SNF)	123	44,895	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	44,895	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	20,256	8,107	6,378	34,741	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,256	8,107	6,378	34,741	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.38%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location
Date started 1/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/1/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 123 and days of care provided 6,378

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basi

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Watseka Rehabilitation & Health Care Cent # 0046847 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	153,635	17,569	1,526	172,730		172,730	4,178	176,908			1
2	Food Purchase		154,785		154,785		154,785	(3,621)	151,164			2
3	Housekeeping	124,243	15,026		139,269		139,269	97	139,366			3
4	Laundry	33,958	10,818		44,776		44,776	7	44,783			4
5	Heat and Other Utilities			93,992	93,992		93,992	689	94,681			5
6	Maintenance	29,330	29,461	2,244	61,035		61,035	6,649	67,684			6
7	Other (specify):* Home Office Benefits							1,421	1,421			7
8	**TOTAL General Services**	341,166	227,659	97,762	666,587		666,587	9,420	676,007			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,286,206	253,333	42,029	1,581,568		1,581,568	25,400	1,606,968			10
10a	Therapy		699	214,094	214,793		214,793	4	214,797			10a
11	Activities	61,942	4,902	1,381	68,225		68,225	13	68,238			11
12	Social Services	67,784	929		68,713		68,713		68,713			12
13	CNA Training											13
14	Program Transportation	8,541			8,541		8,541		8,541			14
15	Other (specify):* Home Office Benefits							5,361	5,361			15
16	**TOTAL Health Care and Programs**	1,424,473	259,863	264,704	1,949,040		1,949,040	30,778	1,979,818			16
	C. General Administration											
17	Administrative	57,905		168,000	225,905		225,905	(138,404)	87,501			17
18	Directors Fees											18
19	Professional Services			8,188	8,188		8,188	15,849	24,037			19
20	Dues, Fees, Subscriptions & Promotion			8,735	8,735		8,735	4,610	13,345			20
21	Clerical & General Office Expense	27,052	10,822	2,025	39,899		39,899	84,033	123,932			21
22	Employee Benefits & Payroll Taxe			256,255	256,255		256,255	2,841	259,096			22
23	Inservice Training & Educatior			808	808		808	1,262	2,070			23
24	Travel and Seminar			1,362	1,362		1,362	1,218	2,580			24
25	Other Admin. Staff Transportatior			16,788	16,788		16,788	5,412	22,200			25
26	Insurance-Prop.Liab.Malpractice			63,516	63,516		63,516	2,789	66,305			26
27	Other (specify):* Home Office Benefits							19,475	19,475			27
28	**TOTAL General Administration**	84,957	10,822	525,677	621,456		621,456	(915)	620,541			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,850,596	498,344	888,143	3,237,083		3,237,083	39,283	3,276,366			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Watseka Rehabilitation & Health Care Center #0046847 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			192,911	192,911		192,911	19,555	212,466			30
31	Amortization of Pre-Op. & Org											31
32	Interest			205,308	205,308		205,308	20,056	225,364			32
33	Real Estate Taxes			37,500	37,500		37,500	34	37,534			33
34	Rent-Facility & Grounds							687	687			34
35	Rent-Equipment & Vehicles			4,570	4,570		4,570	168	4,738			35
36	Other (specify):*											36
37	TOTAL Ownership			440,289	440,289		440,289	40,500	480,789			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,376		57,376		57,376		57,376			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,343	67,343		67,343		67,343			42
43	Other (specify):* Nonallowable Cost			78,321	78,321		78,321	(78,321)				43
44	TOTAL Special Cost Centers		57,376	145,664	203,040		203,040	(78,321)	124,719			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,850,596	555,720	1,474,096	3,880,412		3,880,412	1,462	3,881,874			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See Schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Watseka Rehabilitation & Health Care Center # 0046847 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,488	30		9
10	Interest and Other Investment Income	(21)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(959)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(20)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(52,612)	43		24
25	Fund Raising, Advertising and Promotional	(12,436)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(16,253)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (78,813)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule	$		31
32	Donated Goods-Attach Schedule			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	80,275		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 80,275		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,462		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Programs		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Watseka Rehabilitation & Health Care Center

ID# 0046847

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. - Part A	$ (60)	43	1
2	Labs - Part A	(6,169)	43	2
3	X-Rays - Part A	(146)	43	3
4	Cable TV	(4,629)	43	4
5	Misc income offset	(3,030)	21	5
6	Meal income offset	(929)	2	6
7	Special Events	(1,290)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(16,253)		49

Facility Name & ID Number Watseka Rehabilitation & Health Care Cente # 0046847 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 6A		See Attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organizatior	6 Percent of Ownership	7 Operating Cost of Related Organizatior	8 Difference: Adjustments for Related Organizatior Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 4,178	$ 4,178	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	133	133	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	94	94	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	7	7	4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	636	636	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	5,481	5,481	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,193	1,193	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	6,911	6,911	8
9	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	4	4	9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	958	958	10
11	V	17	Administrative	168,000	Petersen Health Care, Inc.	100.00%	29,596	(138,404)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	8,594	8,594	12
13	V	20	Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	3,912	3,912	13
14	Total			$ 168,000			$ 61,697	$ * (106,303)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Watseka Rehabilitation & Health Care Cente # 0046847 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Clerical & General Office	$	Petersen Health Care, Inc.	100.00%	$ 38,188	$ 38,188	15
16	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	621	621	16
17	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	851	851	17
18	V	25	Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	3,096	3,096	18
19	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	1,130	1,130	19
20	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	8,496	8,496	20
21	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	5,439	5,439	21
22	V	32	Interest		Petersen Health Care, Inc.	100.00%	7,319	7,319	22
23	V	34	Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	687	687	23
24	V	35	Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	168	168	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 168,000			$ 127,692	$ * (40,308)	39

* Total must agree with the amount recorded on line 34 of Schedule VI

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Watseka Rehabilitation & Health Care Cente # 0046847 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	Petersen Health Care II, Inc.	0.00%	$ 16	$ 16	15
16	V	3	Housekeeping		Petersen Health Care II, Inc.	0.00%	3	3	16
17	V	5	Utilities		Petersen Health Care II, Inc.	0.00%	53	53	17
18	V	6	Maintenance		Petersen Health Care II, Inc.	0.00%	1,168	1,168	18
19	V	7	Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	0.00%	228	228	19
20	V	10	Nursing & Medical Records		Petersen Health Care II, Inc.	0.00%	18,489	18,489	20
21	V	11	Activities		Petersen Health Care II, Inc.	0.00%	13	13	21
22	V	15	Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	0.00%	4,403	4,403	22
23	V	19	Professional Services		Petersen Health Care II, Inc.	0.00%	7,255	7,255	23
24	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	0.00%	698	698	24
25	V	21	Clerical & General Office		Petersen Health Care II, Inc.	0.00%	48,875	48,875	25
26	V	23	Inservice Training & Education		Petersen Health Care II, Inc.	0.00%	641	641	26
27	V	24	Travel and Seminar		Petersen Health Care II, Inc.	0.00%	367	367	27
28	V	25	Other Admin. Staff Transport		Petersen Health Care II, Inc.	0.00%	2,316	2,316	28
29	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care II, Inc.	0.00%	1,659	1,659	29
30	V	27	Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	0.00%	10,979	10,979	30
31	V	30	Depreciation		Petersen Health Care II, Inc.	0.00%	10,628	10,628	31
32	V	32	Interest		Petersen Health Care II, Inc.	0.00%	12,758	12,758	32
33	V	33	Real Estate Taxes		Petersen Health Care II, Inc.	0.00%	34	34	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 120,583	$ * 120,583	39

* Total must agree with the amount recorded on line 34 of Schedule VI

SEE ACCOUNTANTS' COMPILATION REPORT

Watseka Rehabilitation & Health Care Center
Provider #: 0046847
01/01/2005 to 12/31/2005

Schedule 6A

VII Related Parties - Page 6

Related Nursing Homes	City
In-State:	
Aledo Rehabilitation & Health Care Center	Aledo, IL
Arcola Health Care Center	Arcola, IL
Arrow Wood Estates of Rock Falls	Rock Falls, IL
Aspen Rehab & Health Care	Silivis, IL
Batavia Rehabilitation & Health Care Center	Batavia, IL
Bement Health Care Center	Bement, IL
Benton Rehabilitation & Health Care Center	Benton, IL
Bloomington Rehabilitation & Health Care Center	Bloomington, IL
Casey Health Care Center	Casey, IL
Cisne Rehabilitation & Health Care Center	Cisne, IL
Countryview Care Center of Macomb	Macomb, IL
Countryview Terrace	Louisville, IL
Decatur Rehabilitation & Health Care Center	Decatur, IL
Eastside Health & Rehabilitation Center	Pittsfield, IL
Eastview Terrace	Sullivan, IL
Effingham Rehabilitation & Health Care Center	Effingham, IL
El Paso Health Care Center	El Paso, IL
Elgin Rehabilitation & Health Care Center	South Elgin, IL
Enfield Rehabilitation & Health Care Center	Enfield, IL
Flora Health Care Center	Flora, IL
Fondulac Rehabilitation & Health Care Center	East Peoria, IL
Havana Health Care Center	Havana, IL
Ironwood Estates of Sandwich	Sandwich, IL
Jonesboro Rehabilitation & Health Care Center	Jonesboro, IL
Kewanee Care Home	Kewanee, IL
McLeansboro Rehabilitation & Health Care Center	McLeansboro, IL
Newman Rehabilitation & Health Care Center	Newman, IL
North Aurora Care Center	Aurora, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie Rose Health Care Center	Pana, IL
Robings Manor Nursing Home	Brighton, IL
Rock Falls Rehabilitation & Health Care Center	Rock Falls, IL
Rosiclare Rehabilitation & Health Care Center	Rosiclare, IL
Royal Oaks Care Center	Kewanee, IL
Sandwich Rehabilitation & Health Care Center	Sandwich, IL
Shelbyville Rehabilitation & Health Care Center	Shelbyville, IL
Sheldon Health Care Center	Sheldon, IL
Sugar Creek Care Center	Watseka, IL
Sullivan Health Care Center	Sullivan, IL
Sunset Manor Nursing Home	Canton, IL
Timbercreek Rehabilitation & Health Care Center	Pekin, IL
Toulon Rehabilitation & Health Care Center	Toulon, IL
Tuscola Health Care Center	Tuscola, IL
Vandalia Rehabilitation & Health Care Center	Vandalia, IL
Watseka Rehabilitation & Health Care Center	Watseka, IL
Out-of-State:	
Meadow Lawn Nursing Center	Davenport, IA

Related Assisted Living	
Kewanee Courtyard Estates	Kewanee, IL
Kewanee Courtyard Village	Kewanee, IL
Monmouth Courtyard Estates	Monmouth, IL
Riverview Estates of Havana	Havana, IL
Simple Blessings	Casey, IL

Other Related Business Entities		
Petersen Health Care, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Health Care II, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Enterprises	Peoria, IL	Management/Bookkeeping
Petersen Health Systems	Peoria, IL	Management/Bookkeeping
Petersen Health Operations, L.L.C.	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Watseka Rehabilitation & Health Care Cent # 0046847 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	3	5.00	Salary	$ 29,596	L17,C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 29,596		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Watseka Rehabilitation & Health Care Center # 0046847 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offic or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization: Petersen Health Care, Inc.
Street Address: 830 West Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	683,169	46	$ 82,166	$ 81,693	34,741	$ 4,178	1
2	2	Food	Patient Days	683,169	46	2,606		34,741	133	2
3	3	Housekeeping	Patient Days	683,169	46	1,857		34,741	94	3
4	4	Laundry	Patient Days	683,169	46	144		34,741	7	4
5	5	Utilities	Patient Days	683,169	46	12,513		34,741	636	5
6	6	Maintenance	Patient Days	683,169	46	107,775	81,080	34,741	5,481	6
7	7	Mgmt. Allocation of Benefits	Patient Days	683,169	46	23,459		34,741	1,193	7
8	10	Nursing and Medical Records	Patient Days	683,169	46	135,903	130,651	34,741	6,911	8
9	10A	Therapy	Patient Days	683,169	46	88		34,741	4	9
10	15	Mgmt. Allocation of Benefits	Patient Days	683,169	46	18,830		34,741	958	10
11	17	Administrative	Patient Days	683,169	46	582,000	582,000	34,741	29,596	11
12	19	Professional Services	Patient Days	683,169	46	168,984		34,741	8,594	12
13	20	Dues, Fees, Subs & Promos	Patient Days	683,169	46	76,921		34,741	3,912	13
14	21	Clerical & General Office	Patient Days	683,169	46	750,958	577,218	34,741	38,188	14
15	23	Inservice Training & Education	Patient Days	683,169	46	12,208		34,741	621	15
16	24	Travel & Seminar	Patient Days	683,169	46	16,731		34,741	851	16
17	25	Other Admin. Staff Transport	Patient Days	683,169	46	60,875		34,741	3,096	17
18	26	Insurance-Prop.Liab.Malp.	Patient Days	683,169	46	22,218		34,741	1,130	18
19	27	Mgmt. Allocation of Benefits	Patient Days	683,169	46	167,067		34,741	8,496	19
20	30	Depreciation	Patient Days	683,169	46	106,965		34,741	5,439	20
21	32	Interest	Patient Days	683,169	46	143,934		34,741	7,319	21
22	34	Rent - Facility & Grounds	Patient Days	683,169	46	13,500		34,741	687	22
23	35	Rent - Equipment & Vehicles	Patient Days	683,169	46	3,305		34,741	168	23
24										24
25	TOTALS					$ 2,511,007	$ 1,452,642		$ 127,692	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Watseka Rehabilitation & Health Care Center # 0046847 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offic or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization: Petersen Health Care II, Inc.
Street Address: 830 West Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Patient Days	241,523	7	$ 114	$	34,741	$ 16	1
2	3	Housekeeping	Patient Days	241,523	7	24		34,741	3	2
3	5	Utilities	Patient Days	241,523	7	370		34,741	53	3
4	6	Maintenance	Patient Days	241,523	7	8,117	6,500	34,741	1,168	4
5	7	Mgmt. Allocation of Benefits	Patient Days	241,523	7	1,587		34,741	228	5
6	10	Nursing & Medical Records	Patient Days	241,523	7	128,534	125,373	34,741	18,489	6
7	11	Activities	Patient Days	241,523	7	93		34,741	13	7
8	15	Mgmt. Allocation of Benefits	Patient Days	241,523	7	30,610		34,741	4,403	8
9	19	Professional Services	Patient Days	241,523	7	50,439		34,741	7,255	9
10	20	Dues, Fees, Subs & Promotions	Patient Days	241,523	7	4,852		34,741	698	10
11	21	Clerical & General Office	Patient Days	241,523	7	339,781	312,613	34,741	48,875	11
12	23	Inservice Training & Education	Patient Days	241,523	7	4,454		34,741	641	12
13	24	Travel & Seminar	Patient Days	241,523	7	2,551		34,741	367	13
14	25	Other Admin. Staff Transport	Patient Days	241,523	7	16,098		34,741	2,316	14
15	26	Insurance-Prop.Liab.Malp.	Patient Days	241,523	7	11,534		34,741	1,659	15
16	27	Mgmt. Allocation of Benefits	Patient Days	241,523	7	76,326		34,741	10,979	16
17	30	Depreciation	Patient Days	241,523	7	73,886		34,741	10,628	17
18	32	Interest	Patient Days	241,523	7	88,696		34,741	12,758	18
19	33	Real Estate Taxes	Patient Days	241,523	7	236		34,741	34	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 838,302	$ 444,486		$ 120,583	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Watseka Rehabilitation & Health Care Cente # 0046847 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	US Bank		X	Mortgage	Varies	1/4/2005	$ 2,960,000	$ 2,895,641	12/18/2011	0.0690	$ 204,218	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,960,000	$ 2,895,641			$ 204,218	9
	B. Non-Facility Related*											
10								Interest income offset			(21)	10
11								Allocated from home office			20,077	11
12								Amortization of loan costs			1,090	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 21,146	14
15	TOTALS (line 9+line14)						$ 2,960,000	$ 2,895,641			$ 225,364	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7 (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Watseka Rehabilitation & Health Care Center **#** 0046847 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report

1. Real Estate Tax accrual used on 2004 report.		$	1
	Allocation from home office		34
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	**2004**	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	**34** 3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$	**37,500** 4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru		$	**37,534** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	**8**
	2001	**9**
	2002	**10**
	2003	**11**
	2004	**12**

Previously not for profit - Estimate based on assessed value.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	**13**
14	PLUS APPEAL COST FROM LINE 5	$	**14**
15	LESS REFUND FROM LINE 6	$	**15**
16	AMOUNT TO USE FOR RATE CALCULATION	$	**16**

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Watseka Rehabilitation & Health Care Center COUNTY Iroquois

FACILITY IDPH LICENSE NUMBER 0046847

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE 309-691-8113 FAX #: 309-691-8622

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Allocation from Home Office		$	$ 34.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$ 34.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Watseka Rehabilitation & Health Care Cente # 0046847 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,000 B. General Construction Type: Exterior Brick & Block Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization [ ] (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortize [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	28,000	2005	$ 120,000	1
2					2
3	TOTALS	28,000		$ 120,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Watseka Rehabilitation & Health Care Cente # 0046847 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	123		2005	1976	$ 2,511,949	$ 80,243	30	$ 83,732	$ 3,489	$ 83,732	4
5											5
6	Allocated from Home Offce		2005		34,619			649	649	649	6
7											7
8											8
	Improvement Type**										
9	Parking lots, sidewalks & landscaping			2005	534,029	35,602	15	35,601	(1)	35,601	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23	2005 - Home Office Allocation - Land Improvements			2005	2,001			62	62	62	23
24	2005 - Home Office Allocation - Building Improvements			2005	57			2	2	2	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Watseka Rehabilitation & Health Care Cente # 0046847 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,082,655	$ 115,845		$ 120,046	$ 4,201	$ 120,046	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numbe Watseka Rehabilitation & Health Care Cente # 0046847 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases	730,259	73,066	73,066		10	73,066	72
73	Fully Depreciated Assets							73
74	Allocated from Home Office			15,354	15,354			74
75	TOTALS	$ 730,259	$ 73,066	$ 88,420	$ 15,354		$ 73,066	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Bus		2005	$ 20,000	$ 4,000	$ 4,000	$	5	$ 4,000	76
77										77
78										78
79										79
80	TOTALS			$ 20,000	$ 4,000	$ 4,000	$		$ 4,000	80

E. Summary of Care-Related Asset

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	3,952,914	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	192,911	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	212,466	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	19,555	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	197,113	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progres

	Description	Cost	
92	ALTA Elevations	$ 1,048	92
93			93
94			94
95		$ 1,048	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column (

Facility Name & ID Number Watseka Rehabilitation & Health Care Center # 0046847 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Home Office				687			6
7	TOTAL				$ 687 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 4,738 Description: Nursing equipment - $425; Copier $4,145; Home office allocation $168
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Watseka Rehabilitation & Health Care Cente # 0046847 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits
(c) For in-house training programs only. Do not include fringe benefits
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	1,000	$ 64,981	$	1,000	$ 64,981	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		130	8,379		130	8,379	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10, C2, C3	hrs		2,165	140,734	699	2,165	141,433	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				47,608		47,608	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen	L39, C2					9,768		9,768	13
14	TOTAL			$	3,295	$ 214,094	$ 58,075	3,295	$ 272,169	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be lis on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Watseka Rehabilitation & Health Care Center **#** 0046847 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 950	$ 950	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	537,622	537,622	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,094	6,094	6
7	Other Prepaid Expenses	15,064	15,064	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 559,730	$ 559,730	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	120,000	120,000	13
14	Buildings, at Historical Cost	3,045,978	3,080,597	14
15	Leasehold Improvements, at Historical Cost		2,058	15
16	Equipment, at Historical Cost	750,259	750,259	16
17	Accumulated Depreciation (book methods)	(192,911)	(197,113)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp See Schedule 17A	265,426	265,426	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,988,752	$ 4,021,227	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,548,482	$ 4,580,957	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 723,907	$ 723,907	26
27	Officer's Accounts Payable	12,699	12,699	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	125,884	125,884	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,810	25,810	31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,500	37,500	32
33	Accrued Interest Payable	16,915	16,915	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Accrued Expenses	16,267	16,267	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 958,982	$ 958,982	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,895,641	2,895,641	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,895,641	$ 2,895,641	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,854,623	$ 3,854,623	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 693,859	$ 726,334	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,548,482	$ 4,580,957	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Watseka Rehabilitation & Health Care Center
Provider #: 0046847
01/01/2005 to 12/31/2005

Schedule 17A

XV. Balance Sheet. SUPPORT SCHEDULE

	Operating	After Consolidation
Line 22 - Other Long-Term Assets		
Construction in Progress	1,048	1,048
Goodwill	257,851	257,851
Loan Costs	6,527	6,527
	265,426	265,426

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Watseka Rehabilitation & Health Care Center # 0046847 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (281)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (281)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	694,140	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 694,140	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 693,859	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Watseka Rehabilitation & Health Care Center # 0046847 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Car	$ 3,578,238	1
2	Discounts and Allowances for all Level	287,966	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,866,204	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	439,445	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 439,445	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	929	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	199,245	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	65,678	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 265,852	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income**	21	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 21	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	3,030	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,030	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,574,552	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	666,587	31
32	Health Care	1,949,040	32
33	General Administration	621,456	33
	B. Capital Expense		
34	Ownership	440,289	34
	C. Ancillary Expense		
35	Special Cost Centers	135,697	35
36	Provider Participation Fee	67,343	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,880,412	40
41	**Income before Income Taxes (line 30 minus line 40)****	694,140	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 694,140	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity is a cash basis taxpayer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Watseka Rehabilitation & Health Care Cente # 0046847 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,301	2,301	$ 60,929	$ 26.48	1
2	Assistant Director of Nursing	1,449	1,449	33,752	23.29	2
3	Registered Nurses	3,760	3,760	115,234	30.65	3
4	Licensed Practical Nurses	17,808	17,856	355,668	19.92	4
5	CNAs & Orderlies	66,666	66,689	610,694	9.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,730	3,730	41,172	11.04	8
9	Activity Director	2,058	2,058	26,231	12.75	9
10	Activity Assistants	3,335	3,335	35,711	10.71	10
11	Social Service Workers	5,986	5,986	67,784	11.32	11
12	Dietician					12
13	Food Service Supervisor	2,033	2,193	26,861	12.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,418	14,418	126,774	8.79	15
16	Dishwashers					16
17	Maintenance Worker	3,209	3,287	29,330	8.92	17
18	Housekeepers	13,536	13,536	124,243	9.18	18
19	Laundry	4,249	4,249	33,958	7.99	19
20	Administrator	2,004	2,004	57,905	28.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,804	2,804	27,052	9.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Care Plan Coordinator	1,150	1,150	8,541	7.43	32
33	Other(specify) Transportation	4,008	4,008	68,757	17.15	33
34	TOTAL (lines 1 - 33)	154,504	154,813	$ 1,850,596 *	$ 11.95	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	30	$ 1,526	L1, C3	35
36	Medical Director	12 visits	7,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	11 visits	1,100	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultan				41
42	Respiratory Therapy Consultan				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Rehab Consultant	1,364	40,929	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,394	$ 50,755		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number: Watseka Rehabilitation & Health Care Cente # 0046847 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carolyn Bessette	Administrator	0	$ 9,031
Linda Hasbargen	Administrator	0	48,874
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.			$ 57,905

B. Administrative - Other

Description	Amount
Management Fees (eliminated in column 7)	$ 168,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 168,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Advanced Answers on Demand	Computer Services	$ 2,832
CLR Computer Technologies	Computer Services	1,228
LTC Solutions	Computer Services	1,978
Miscellaneous	Computer Services	999
Other professional services	Professional Services	1,151
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 8,188

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,039
Unemployment Compensation Insurance	53,023
FICA Taxes	127,664
Employee Health Insurance	31,954
Employee Meals	2,841
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	370
Employee Morale	4,205
TOTAL (agree to Schedule V, line 22, col.8)	$ 259,096

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,314
Health Care Worker Background Check	
(Indicate # of checks performed 95)	1,150
Licenses	228
Subscriptions	43
Allocated from Home Office	4,610
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,345

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,222
Seminar Expense	140
Allocated from Home Office	1,218
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,580

* Attach copy of IMRF notifications

**See instructions.

Watseka Rehabilitation & Health Care Center
Facility # 0046847
January 1, 2005 - December 31, 2005 Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)		8,188
Allocated from Home Office		
Legal	163	
Other	15,686	15,849
Total (agree to Schedule V, line 19, column 8)		24,037

Facility Name & ID Number Watseka Rehabilitation & Health Care Center # 0046847 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6			N/A										
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Watseka Rehabilitation & Health Care Center **#** 0046847 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost repor **No**
If YES, give association name and amount **N/A**

(3) Did the nursing home make political contributions or payments to a politic action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at th end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases **Yes**
What was the average life used for new equipment added during this perioc **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expens and the location of this expense on Sch. V. $ **10,553** Line **10,2**

(7) Have all costs reported on this form been determined using accounting procedur consistent with prior reports? **Yes** If NO, attach a complete explanation

(8) Are you presently operating under a sale and leaseback arrangemen **No**
If YES, give effective date of lease **N/A**

(9) Are you presently operating under a sublease agreemen ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took ove

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmer during this cost report period. $ **67,343**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? **No** If YES, attach an explanation of the allocation

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed t the Department, in addition to the daily rate, been properly classifie in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services f the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attac a schedule which explains how all related costs were allocated to these function

(15) Indicate the cost of employee meals that has been reclassified to employee benefi on Schedule V. $ **2,841** Has any meal income been offset agains related costs? **Yes** Indicate the amount $ **929**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel **No**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation fc residents? **No** If YES, please indicate the amount of income earned from such program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients **N/A**
d. Have vehicle usage logs been maintained **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all oth times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjust out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm **Yes**
Firm Name: **Ginoli and Company** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this cop been attached? **No** If no, please explain **Audit in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted o out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of servic performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fee

RECONCILIATION REPORT **12:15 PM** **5/16/2006**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	1,462	equal to	1,462	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	225,364	equal to	225,364	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	37,534	equal to	37,534	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	212,466	equal to	212,466	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	687	equal to	687	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	4,738	equal to	4,738	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	214,793	equal to	214,793	0	O.K.	Pg16 Z12+Z14.	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	58,075	equal to	58,075	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	666,587	equal to	666,587	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,949,040	equal to	1,949,040	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	621,456	equal to	621,456	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	440,289	equal to	440,289	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	135,697	equal to	135,697	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	67,343	equal to	67,343	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,286,206	equal to	1,286,206	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	61,942	equal to	61,942	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	67,784	equal to	67,784	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	153,635	equal to	153,635	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	29,330	equal to	29,330	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	124,243	equal to	124,243	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	33,958	equal to	33,958	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	57,905	equal to	57,905	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	27,052	equal to	27,052	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,850,596	equal to	1,850,596	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	1,526	< or = to	1,526	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	7,200	< or = to	7,200	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	42,029	< or = to	42,029	0	O.K.	Pg20 X14..X16+	B. & C.	I7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	1,381	-1,381	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	57,905	equal to	57,905	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	168,000	equal to	168,000	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	8,188	equal to	8,188	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	259,096	equal to	259,096	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	13,345	equal to	13,345	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	2,580	equal to	2,580	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	67,343	equal to	67,343	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	2,841	< or = to	2,841	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	2,841	equal to	2,841	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	6,378	equal to	6,378	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	80,275	equal to	80,275	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	2,895,641	equal to	2,895,641	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	37,500	equal to	37,500	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	120,000	equal to	120,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	3,082,655	equal to	3,082,655	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	750,259	equal to	750,259	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	197,113	equal to	197,113	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	693,859	equal to	693,859	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	694,140	equal to	694,140	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..:	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	4,548,482	equal to	4,548,482	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Watseka Rehabilitation & Health Care Center
IDHFS Comparative Data - Per Resident Day Cost
Year Ending 12/31/2005

Enter your HSA # in next column =====> 4
Census (Pulls from Page 2) 34,741

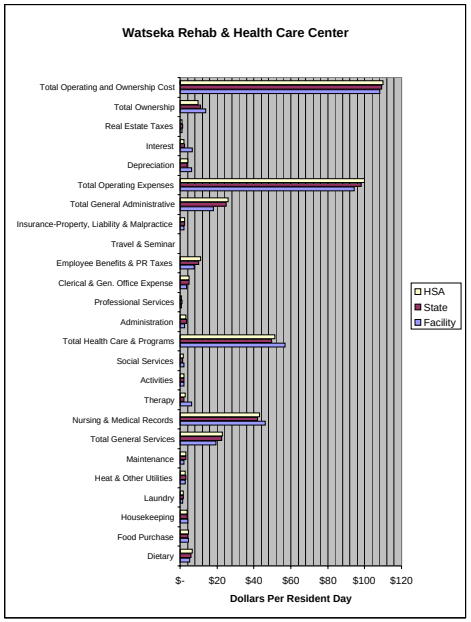
Cost Report Line	Description	Your Facility	Average Median Cost Per Day (2003) State	HSA
1	Dietary	5.09	6.01	6.48
2	Food Purchase	4.35	4.31	4.40
3	Housekeeping	4.01	3.70	3.68
4	Laundry	1.29	1.85	1.90
5	Heat & Other Utilities	2.73	2.95	2.93
6	Maintenance	1.95	3.01	3.03
8	Total General Services	19.46	22.58	22.99
10	Nursing & Medical Records	46.26	41.83	43.12
10A	Therapy	6.18	2.10	2.69
11	Activities	1.96	1.91	1.92
12	Social Services	1.98	1.42	1.64
16	Total Health Care & Programs	56.99	49.48	51.22
17	Administration	2.52	3.36	3.15
19	Professional Services	0.69	0.99	0.85
21	Clerical & Gen. Office Expense	3.57	4.79	4.97
22	Employee Benefits & PR Taxes	7.46	10.09	11.01
24	Travel & Seminar	0.07	0.08	0.13
26	Insurance-Property, Liability & Malpractice	1.91	2.58	2.55
28	Total General Administrative	17.86	24.94	26.11
29	Total Operating Expenses	94.31	98.06	100.03
30	Depreciation	6.12	3.70	4.08
32	Interest	6.49	2.54	1.96
33	Real Estate Taxes	1.08	1.38	1.08
37	Total Ownership	13.84	11.11	9.80
	Total Operating and Ownership Cost	108.15	109.17	109.83

Notes:
Your Facility data is from page 3, column 8 of your 2005 Medicaid cost report, divided by your annual census.

The Average Median Cost Per Day for the **State** and your **HSA** is taken from 2003 data available from the Illinois Department of Healthcare and Family Services and corresponds with the respective cost report data after final adjustments.

IDHFS LTC Profiles
LTC Median Per Diem Cost by HSA - 2003 Cost Reports
2003 (Run June 1, 2004) **UN-INFLATED**

Cost Report Line	Description	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11	10th %	90th %
1	Dietary	6.01	7.02	6.48	5.50	6.48	5.48	6.06	6.06	6.06	5.60	7.02	5.70	4.13	9.81
2	Food Purchase	4.31	4.47	4.40	4.27	4.40	3.99	4.31	4.31	4.31	4.28	4.47	4.11	3.36	6.04
3	Housekeeping	3.70	3.59	3.68	2.91	3.68	3.40	4.05	4.05	4.05	3.97	3.59	3.61	2.48	5.80
4	Laundry	1.85	2.23	1.90	1.79	1.90	2.10	1.59	1.59	1.59	1.69	2.23	2.13	0.91	3.14
5	Heat & Other Utilities	2.95	3.17	2.93	2.94	2.93	2.71	2.93	2.93	2.93	2.91	3.17	2.95	2.05	4.25
6	Maintenance	3.01	3.26	3.03	2.99	3.03	2.55	3.21	3.21	3.21	3.05	3.26	2.82	1.92	5.12
8	**TOTAL GENERAL SERVICES**	**22.58**	**24.49**	**22.99**	**21.14**	**22.99**	**21.47**	**22.65**	**22.65**	**22.65**	**22.45**	**24.49**	**21.73**	**17.57**	**31.51**
10	Nursing & Medical Records	41.83	42.52	43.12	38.37	43.12	33.78	45.12	45.12	45.12	47.22	42.52	42.15	27.25	64.47
10A	Therapy	2.10	1.86	2.69	3.34	2.69	3.47	1.45	1.45	1.45	2.41	1.86	2.24	-	10.55
11	Activities	1.91	2.18	1.92	1.61	1.92	1.48	2.16	2.16	2.16	2.05	2.18	1.54	1.06	3.45
12	Social Services	1.42	1.45	1.64	1.05	1.64	1.09	1.60	1.60	1.60	1.12	1.45	1.27	0.58	3.00
16	**TOTAL HEALTH CARE & PROGRAMS**	**49.48**	**50.39**	**51.22**	**46.39**	**51.22**	**41.58**	**52.34**	**52.34**	**52.34**	**54.96**	**50.39**	**49.49**	**32.10**	**77.23**
17	Administration	3.36	3.33	3.15	3.15	3.15	3.60	3.46	3.46	3.46	3.04	3.33	3.17	1.71	7.21
19	Professional Services	0.99	1.09	0.85	0.83	0.85	0.76	1.12	1.12	1.12	1.13	1.09	0.77	0.07	3.44
21	Clerical & Gen. Office Expense	4.79	4.32	4.97	3.98	4.97	3.46	5.56	5.56	5.56	5.04	4.32	4.25	2.49	10.78
22	Employee Benefits & PR Taxes	10.09	10.42	11.01	8.88	11.01	7.67	10.51	10.51	10.51	11.38	10.42	9.08	6.33	19.34
24	Travel & Seminar	0.08	0.10	0.13	0.10	0.13	0.13	0.06	0.06	0.06	0.05	0.10	0.07	-	0.43
26	Insurance-Property, liability & Malpractice	2.58	2.47	2.55	2.35	2.55	2.22	2.85	2.85	2.85	2.19	2.47	2.61	0.88	4.32
28	**TOTAL GENERAL ADMINISTRATIVE**	**24.94**	**25.31**	**26.11**	**23.02**	**26.11**	**21.37**	**25.81**	**25.81**	**25.81**	**26.59**	**25.31**	**22.93**	**16.95**	**39.14**
29	**TOTAL OPERATING EXPENSES**	**98.06**	**100.77**	**100.03**	**92.47**	**100.03**	**88.05**	**100.96**	**100.96**	**100.96**	**103.01**	**100.77**	**94.71**	**69.40**	**142.56**
30	Depreciation	3.70	3.82	4.08	3.29	4.08	2.54	4.11	4.11	4.11	3.54	3.82	3.38	1.01	8.43
32	Interest	2.54	2.81	1.96	2.09	1.96	1.41	4.05	4.05	4.05	2.63	2.81	1.50	-	11.53
33	Real Estate Taxes	1.38	0.92	1.08	0.82	1.08	0.80	3.20	3.20	3.20	1.36	0.92	1.11	-	4.85
37	**TOTAL OWNERSHIP**	**11.11**	**9.73**	**9.80**	**8.00**	**9.80**	**7.04**	**14.54**	**14.54**	**14.54**	**11.02**	**9.73**	**8.39**	**3.76**	**23.58**
	TOTAL OPERATING & OWNERSHIP CC	**109.17**	**110.50**	**109.83**	**100.47**	**109.83**	**95.09**	**115.50**	**115.50**	**115.50**	**114.03**	**110.50**	**103.10**	**73.16**	**166.14**



	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	153,635	17,569	1,526	172,730	0	172,730	4,178	176,908
2. Food Purchase	0	154,785	0	154,785	0	154,785	-3,621	151,164
3. Housekeeping	124,243	15,026	0	139,269	0	139,269	97	139,366
4. Laundry	33,958	10,818	0	44,776	0	44,776	7	44,783
5. Heat and Other Utilities	0	0	93,992	93,992	0	93,992	689	94,681
6. Maintenance	29,330	29,461	2,244	61,035	0	61,035	6,649	67,684
7. Other (specify)*	0	0	0	0	0	0	1,421	1,421
8. Total General Services	341,166	227,659	97,762	666,587	0	666,587	9,420	676,007
9. Medical Director	0	0	7,200	7,200	0	7,200	0	7,200
10. Nursing & Medical Records	1,286,206	253,333	42,029	1,581,568	0	1,581,568	25,400	1,606,968
10a. Therapy	0	699	214,094	214,793	0	214,793	4	214,797
11. Activities	61,942	4,902	1,381	68,225	0	68,225	13	68,238
12. Social Services	67,784	929	0	68,713	0	68,713	0	68,713
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	8,541	0	0	8,541	0	8,541	0	8,541
15. Other (specify)*	0	0	0	0	0	0	5,361	5,361
16. Total Health Care & Programs	1,424,473	259,863	264,704	1,949,040	0	1,949,040	30,778	1,979,818
17. Administrative	57,905	0	168,000	225,905	0	225,905	-138,404	87,501
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	8,188	8,188	0	8,188	15,849	24,037
20. Fees, Subscriptions & Promotion	0	0	8,735	8,735	0	8,735	4,610	13,345
21. Clerical & General Office	27,052	10,822	2,025	39,899	0	39,899	84,033	123,932
22. Employee Benefits & Payroll	0	0	256,255	256,255	0	256,255	2,841	259,096
23. Inservice Training & Education	0	0	808	808	0	808	1,262	2,070
24. Travel and Seminar	0	0	1,362	1,362	0	1,362	1,218	2,580
25. Other Admin. Staff Trans	0	0	16,788	16,788	0	16,788	5,412	22,200
26. Insurance-Prop.Liab.Malpractice	0	0	63,516	63,516	0	63,516	2,789	66,305
27. Other (specify)*	0	0	0	0	0	0	19,475	19,475
28. Total General Adminis	84,957	10,822	525,677	621,456	0	621,456	-915	620,541
29. Total General Administrative	1,850,596	498,344	888,143	3,237,083	0	3,237,083	39,283	3,276,366
30. Depreciation	0	0	192,911	192,911	0	192,911	19,555	212,466
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	205,308	205,308	0	205,308	20,056	225,364
33. Real Estate	0	0	37,500	37,500	0	37,500	34	37,534
34. Rent - Facility & Grounds	0	0	0	0	0	0	687	687
35. Rent - Equipment & Vehicles	0	0	4,570	4,570	0	4,570	168	4,738
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	440,289	440,289	0	440,289	40,500	480,789
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	57,376	0	57,376	0	57,376	0	57,376
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	67,343	67,343	0	67,343	0	67,343
43. Other (specify):*	0	0	78,321	78,321	0	78,321	-78,321	0
44. Total Special Cost Ce	0	57,376	145,664	203,040	0	203,040	-78,321	124,719
45. Grand Total	1,850,596	555,720	1,474,096	3,880,412	0	3,880,412	1,462	3,881,874

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	950	950
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	537,622	537,622
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	6,094	6,094
7. Other Prepaid Expenses	15,064	15,064
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	559,730	559,730
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	120,000	122,058
14. Buildings, at Historical Cost	3,045,978	3,080,597
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	750,259	750,259
17. Accumulated Depreciation (book methods)	-192,911	-197,113
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	265,426	265,426
23. other (specify):	0	0
24. Total Long-Term Assets	3,988,752	4,021,227
25. Total Assets	4,548,482	4,580,957
CURRENT LIABILITIES		
26. Accounts Payable	723,907	723,907
27. Officer's Accounts Payable	12,699	12,699
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	125,884	125,884
31. Accrued Taxes Payable	25,810	25,810
32. Accrued Real Estate Taxes	37,500	37,500
33. Accrued Interest Payable	16,915	16,915
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	0	0
37. Other Current Liabilities (specify):	16,267	16,267
38. Total Current Liabilities	958,982	958,982
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	2,895,641	2,895,641
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	2,895,641	2,895,641
46.Total Liabilities	3,854,623	3,854,623
47.Total Equity	693,859	726,334
48.Total Liabilities and Equity	4,548,482	4,580,957

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,578,238
2. Discounts and Allowances for all Levels	287,966
Subtotal - Inpatient Care	3,866,204
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	439,445
7. Oxygen	0
Subtotal - Anciliary Revenue	439,445
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	929
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	199,245
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	65,678
22. Laundry	0
Subtotal - Other Operating Revenue	265,852
24. Contributions	0
25. Interest and Other Investments Income	21
Subtotal - Non-Operating Revenue	21
27. Other Revenue (specify):	3,030
28. Other Revenue (specify):	0
Subtotal - Other Revenue	3,030
30. Total Revenue	4,574,552
31. General Services	666,587
32. Health Care	1,949,040
33. General Administration	621,456
34. Ownership	440,289
35. Special Cost Centers	135,697
35. Provider Participation Fee	67,343
37. Other	0
40. Total Expenses	3,880,412
41. Income Before Income Taxes	694,140
42. Income Taxes	0
43. Net Income or Loss for the Year	694,140